General Assembly

Raised Bill No. 6927

January Session, 2005

LCO No. **4399**

_____HB06927HS_APP032905___

Referred to Committee on Human Services

Introduced by:
(HS)

AN ACT CONCERNING RESTORATION OF SERVICES AVAILABLE UNDER THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 17b-191 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(b) **[**No earlier than September 1, 2003, but not later than October 1, 2003, the**]** The state-administered general assistance program **[**pursuant to this section and any general assistance program operated by a town**]** shall provide cash assistance of (1) **[**two hundred**]** three hundred fifty dollars per month to a single unemployable person upon determination of such person's unemployability; (2) two hundred dollars per month for a single transitional individual who is required to pay for shelter; and (3) one hundred fifty dollars per month for a single transitional individual who is not required to pay for shelter. No earlier than September 1, 2003, but not later than October 1, 2003, eligible families shall receive cash assistance in an amount that is fifty dollars less than the standard of assistance such family would receive

under the temporary family assistance program. The standard of assistance paid for individuals residing in rated boarding facilities, shall remain at the level in effect on August 31, 2003. No individual shall be eligible for cash assistance under the program if eligible for cash assistance under any other state or federal cash assistance program.

Sec. 2. Section 17b-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. **[**Not later than October 1, 2003, each**]** Each person eligible for state-administered general assistance shall be entitled to receive medical care through a federally qualified health center or other primary care provider as determined by the commissioner. The Commissioner of Social Services shall determine appropriate service areas and shall, in the commissioner's discretion, contract with community health centers, other similar clinics, and other primary care providers, if necessary, to assure access to primary care services for recipients who live farther than a reasonable distance from a federally qualified health center. The commissioner shall ensure the provision of medical transportation for eligible persons to and from primary care providers, hospital care, and for all other services covered under this program to the same extent as is provided under the Medicaid program. The commissioner shall assign and enroll eligible persons in federally qualified health centers and with any other providers contracted for the program because of access needs. **[**Not later than October 1, 2003, each**]** Each person eligible for state-administered general assistance shall be entitled to receive hospital services. **[**Medical services**]** Services required to be covered under the program shall be **[**limited to the services provided by a federally qualified health center, hospital, or other provider contracted for the program at the commissioner's discretion because of access needs**]** those covered under the Medicaid program, except long-

term care and services available pursuant to a home and community-based services waiver under Section 1915(c) of the Social Security Act shall not be covered. The commissioner shall ensure that ancillary services and specialty services are provided by a federally qualified health center, hospital, or other providers contracted for the program at the commissioner's discretion. **[**Ancillary services include, but are not limited to, radiology, laboratory, and other diagnostic services not available from a recipient's assigned primary-care provider, and durable medical equipment. Specialty services are services provided by a physician with a specialty that are not included in ancillary services. In no event shall ancillary or specialty services provided under the program exceed such services provided under the state-administered general assistance program on July 1, 2003.**]** Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person eligible for Medicaid shall be eligible to receive medical care through the state-administered general assistance program. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.

(b) Recipients covered by a general assistance program operated by

a town shall be assigned and enrolled in federally qualified health centers and with any other providers in the same manner as recipients of medical assistance under the state-administered general assistance program pursuant to subsection (a) of this section.

[(c) On and after October 1, 2003, pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. Prior to said date, pharmacy**]**

(c) Pharmacy services shall be provided to recipients of state-administered general assistance as provided under the Medicaid program. Recipients **[**who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified health center that does not have a contract for pharmacy services**]** shall receive pharmacy services at pharmacies designated by the commissioner.

(d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. Recipients shall receive medically necessary covered services from a provider other than one under contract with the commissioner, or with a managed care organization or other entity under this program, if such services are not otherwise available to the recipient. The commissioner shall **[**, within available appropriations, make payments to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner**]** make payments to all providers of

services covered under this program in accordance with the providers' established Medicaid rates. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions, including a grievance process for recipients to access review of a denial of coverage for a specific medical service **[**, and to operate the program in whole or in part**]** provided such organization or entity is not paid on a capitated or per member per month basis. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies. **[**A recipient who has exhausted the grievance process established through such contract and wishes to seek further review of the denial of coverage for a specific medical service may request a hearing in accordance with the provisions of section 17b-60.**]**

[(e) Each federally qualified health center participating in the program shall, within thirty days of August 20, 2003, enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b to provide pharmacy services to recipients at Federal Supply Schedule costs. Each such health center may establish an on-site pharmacy or contract with a commercial pharmacy to provide such pharmacy services.**]**

[(f)**]** (e) The Commissioner of Social Services shall **[**, within available appropriations,**]** make payments to hospitals for inpatient services **[**based on their pro rata share of the cost of services provided or the number of clients served, or both**]** in accordance with the hospitals' established Medicaid rates. The Commissioner of Social Services shall **[**, within available appropriations,**]** make payments for any ancillary or specialty services provided to state-administered general assistance recipients under this section **[**based on a methodology determined by the commissioner**]** in accordance with the providers' established Medicaid rates.

[(g) On or before March 1, 2004, the Commissioner of Social Services

shall seek a waiver of federal law under the Health Insurance Flexibility and Accountability demonstration initiative for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under the state-administered general assistance program. The provisions of section 17b-8 shall apply to this section.**]**

(f) Applicants for and recipients of benefits under the state-administered general assistance program shall be entitled to timely written notice of all adverse decisions on requests for services under the program and to not less than ten days' advance written notice of all terminations, reductions, suspensions or modifications of services under the program.

(g) Under the state-administered general assistance program, the terms "medical necessity", "medically necessary", "medically appropriate" and "medical appropriateness" shall have the same meaning ascribed to them under the Medicaid program.

(h) The commissioner, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 3. Section 17b-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

A person whose application for state-administered general assistance cash or medical benefits is denied **[**or**]** in whole or in part; whose receipt of such assistance is terminated, suspended, reduced or modified; or who is unable to obtain timely access to medical benefits covered under this program or to an out-of-network provider needed for appropriate treatment may request a hearing pursuant to section

17b-60. **[**, provided a**]** A recipient of medical benefits who seeks **[**review of**]** a hearing with regard to the denial of coverage for a specific medical service by a managed care organization or other entity under contract with the department to perform administrative functions shall exhaust the grievance process available pursuant to section 17b-192 prior to **[**requesting**]** receiving such a hearing. A recipient who, after exhausting the grievance process available pursuant to section 17b-192, as amended by this act, remains aggrieved may request a hearing pursuant to section 17b-60 and such hearing shall be scheduled not later than thirty days after the date of receipt of such request for a hearing.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2005*	17b-191(b)
Sec. 2	*July 1, 2005*	17b-192
Sec. 3	*October 1, 2005*	17b-193

HS *Joint Favorable C/R* APP